TO: ALL PROSPECTIVE MEDICAID PROVIDERS

Thank you for your inquiry concerning participation in the Utah Medicaid Program. This package outlines procedures for enrolling as a Utah Medicaid provider.

Please complete the forms as indicated and mail or fax to the address below. You will be notified approximately three weeks from the receipt of all required documentation of the results of your application.

X	Utah Medicaid provider application (please retain a copy for your records)
X	Copy of professional or business license (see page 2)
X	Proof of Medicare Certification for *Institutional* providers (see page 2) and one of the following to show current participation: ▸ Current letter of accreditation (JCAHO or AOA) ▸ Letter from HHS, CMS, or Medicare intermediary showing current enrollment ▸ Current Medicare EOB
X	Copy of IRS Form W-9 with current Taxpayer Identification Number (see page 2, Box 8)
X	Ownership Disclosure information
X	Utah Medicaid provider agreement, signed and dated
____	Other: _____

To receive a Provider Manual, complete the order form you will receive with your Medicaid Provider Number notification letter. The manual contains information on general policy, limitations of coverage, and reimbursement policy for your specific type of service. The Provider Manual also includes instructions for completing claim forms, an example and explanation of the remittance statement, and a description of Medicaid's automated payment system.

Thank you for your interest in the Utah Medicaid program.

Sincerely,

PROVIDER ENROLLMENT
Bureau of Medicaid Operations

Mailing Address: P.O. Box 143106 - Salt Lake City, UT 84114-3106
Telephone (801) 538-6155 - (800) 662-9651 - facsimile (801) 538-6805 - www.health.utah.gov

LICENSE REQUIREMENTS

If license is for:	License required is:
Individual (Professional)	State Professional License (for physical location of service)
Pharmacy	State Retail Pharmacy License (if mail order, requires Utah license, also)
Laboratory	CLIA Certification - Registration, Waiver, PPMP, or Accreditation
Medical Supplier Optical Supplier	Local Business License as a Medical Supplier Local Business License as an Optical Supplier
Alcohol & Drug Center Mental Health Center Day Treatment Center Residential Treatment Facility Child Placement Agency	License from Utah Department of Human Services Contact Division of Services for People with Disabilities
Ambulance Air Ambulance	State Ambulance Services Operation License State Ambulance Services Operation License and FAA Certification
Home Health Agency	License from Utah Department of Health (for personal care services only), Approval from CMS for Medicare Participation (full services)
General Hospital Mental Hospital (Utah only) Nursing Home General Chronic Disease Hospital Instit Mental Disease (Utah only) State Training School (Utah only) Rural Health Clinic	Certification & Transmittal from Medicare/Medicaid Program Certification & Resident Assessment or proof of Medicare Certification and most recent letter of Accreditation Same as General Hospital plus approval from Medicare/Medicaid Program Certification & Resident Assessment Certification & Transmittal from Medicare/Medicaid Program Certification & Resident Assessment Certification & Transmittal from Medicare/Medicaid Program Certification & Resident Assessment or proof of Medicare certification and most recent letter of Accreditation Certification & Transmittal and approval from Medicare/Medicaid Program Certification & Resident Assessment RHC approval letter from CMS Regional Office

INSTRUCTIONS FOR COMPLETING THE MEDICAID PROVIDER APPLICATION

Please **do not** enter information into the right area. These fields are for State Office use only.

Box 1. Name. Enter your first name, middle initial, last name and title (i.e., John J. Jones, M.D.) if you are an individual provider. Otherwise, enter your group name as you wish it to appear on your check.

Box 2. Area – Telephone. Enter the area code and telephone number we may use for billing inquiries.

Pay-To Address – These fields identify where your Medicaid Reimbursement and Remittance Statements will be mailed (Boxes 3-8).

Box 3. Suite. Enter the suite number of your "Pay-To" office.

Box 4. Fax Number. Enter your fax number.

Box 5. Street or PO Box Number. Enter the address you want Checks and Remittance Statements mailed.

Box 6. City/State. Enter your Pay-To City and State.

Box 7. 9-Digit Zip Code. Enter your nine-digit postal zip code.

Box 8. W-9 Name (DBA Name). Enter the name that appears on your IRS W-9 Form. Attach a copy of your IRS W-9 form to the application. This form may be obtained from your local library, US Post Office, by calling the IRS "Need a Tax Form" number at 800 829-3676 or by visiting their Internet web site at www.irs.gov/forms_pubs/formpub.html.

Physical Location. – If your Physical Office Location is different than your "Pay-To"Address (Boxes 9-12). If this information is the same as "Pay-To" skip to next section.

Box 9. Street. Enter the "Physical" location of your office. Include your suite number (no P.O. Boxes).

Box 10. City/State. Enter your City and State.

Box 11. 9-Digit Zip Code. Enter your nine-digit postal zip code.

Box 12. County. Enter the county which your physical site is located within.

Address for Receiving Medicaid Information Bulletins (MIBs) – If you want your MIBs to go to a different address than your "Pay-To" (Boxes 13-18).

Box 13. Enter your e-mail address for receiving Medicaid notifications.

Box 14. Attention. If you want MIBs sent to a person's particular attention, enter that information here.

Box 15. Street. Enter the mailing address you want MIBs to be sent.

Box 16. Suite. Enter the suite number you want MIBs to be sent. zip code.

Box 17. City/State. Enter the mailing City and State.

Box 18. 9-Digit Zip Code. Enter your nine-digit postal

Provider Information – Enter only when applicable (Boxes 19-37).

Box 19. License Number. (Applicable to Professionals and Corporations licensed by the Utah Department of Commerce). Enter your professional license number and attach a copy of your Professional/Business license. Refer to table of Licensure Requirements for proper credential information (page 2).

Box 20. EDI Trading Partner Number. (Applicable to providers sending electronic claims). For inquiries contract UHIN 801 466-7705). Enter your EDI Trading Partner Number.

Box 21. DEA Number. (Applicable to pharmacies and providers with prescriptive practices) – Enter your DEA License Number.

Box 22. CLIA Number. (Applicable to those who bill for lab procedures.) Enter your 10-digit CLIA Certificate number.

Box 23. UPIN Number. Enter your UPIN number for referral purposes. Obtain a UPIN number from Medicare. Medicare Number. Enter your Medicare number.

Box 24. National Provider Identifier (NPI). (Applicable to providers participating in the National Provider System.) - Enter your NPI.

Boxes 25-26.

Social Security Number. All individuals enrolling must supply their personal social security number, Medicaid payments will be reported as income to the individual's Employer Identification Number (EIN) if shown in Box 26. A social security number is not required for corporate entities, namely, Medical Suppliers, Pharmacies, Home Health Agencies, Ambulances, etc.

Individuals who are employees of, or contract with, a corporate provider must give **both** their social security number and their employer's Employer Identification Number (EIN).

Employer Identification Number. To assure proper IRS 1099 reporting, all corporate providers must supply their Employer Identification Number (EIN).

Note: The number selected for IRS reporting must coordinate with the name being used in Box 8 (Tax Name or DBA Name) or Box 1 (Name).

Box 27. Group Practice Provider Number. (Applicable to Groups already established by Utah Medicaid). If you are an

established group practice with Utah Medicaid, enter your twelve-digit Provider Number in this field. If you are requesting a group practice number, or affiliation to a non-established group practice, this field should remain blank.

Box 28. Name of Group Affiliation. (Applicable to all individuals requesting affiliation to a new or previously established Group Practice). Enter the name of the Group or Clinic which you wish to be affiliated to. Also, see page 5 for instructions on establishing a Group Practice.

Box 29. Provider Type. (Applicable to All) - Specify the one Provider Type you are applying for (see following list of Provider Types recognized by Utah Medicaid).

Adult Day Care
Agency
Alcohol and Drug Center
Ambulance
Ambulatory Surg Cntr, Free Standing
Audiologist
Birthing Center, Free Standing
Certified Nurse Midwife
Certified Social Worker+
Clinical Social Worker (LCSW)*+
Dentist
Diabetes Self Management Educator
Dialysis Center
Dietician+
Emergency Response System
Federally Qualified Health Center (FQHC)
Fixed Wing Aircraft
Group Practice
Health Educator (Childbirth Educator)+
Helicopter
HMO
Home Delivered Meals
Home Health Agency
Hospice
Hospital, Chronic Disease
Hospital, General
Hospital, Mental
ICF/MR Day Treatment
Independent Lab and/or X-Ray
Licensed Child Placement Agency
Licensed Day Treatment Facility
Licensed Home Health Services
Licensed Practical Nurse +
Licensed Res Treatment Facility
Licensed Residential & Day Treatment Facility
Marriage/Family Therapist+
Medical Supplier (Includes DME & non-DME)
Mental Health Center
Non-Medical Transportation
Nurse Anesthetist
Nurse Practitioner☼
Nursing Home, General
Occupational Therapist
Optical Supplier
Optometrist
Oral Surgeon
Osteopath
Personal Waiver service Agent
Pharmacy
Physical Therapist
Physician
Podiatrist
Psychologist
PT/OT Rehabilitation Center
Public Health Department
QMB (Crossover Only)*
Registered Nurse+
Rural Health Clinic (RHC)
Social Service Worker (SSW)+
Speech Pathologist

Key to Abbreviations

* May only bill for Medicare Crossover

\+ *Baby-Your-Baby Services*

☼ Requires American Academy of Nurse Practitioners (AANP) Certification as a Family Nurse Practitioner, or American Nurses Credentialing Center (ANCC) Certification as a Family or Pediatric Nurse Practitioner.

Box 30. Begin Date. Specify the Date you wish to have your Medicaid Provider number activated. You may request a Retro-Active date, however, it must be within the scope of your Professional/Business Licensure dates.

Box 31. Categories of Service. (Applicable to All) – Specify the Categories of Service you are applying for (see following list of Categories of Service recognized by Utah Medicaid).

Ambulatory Surgical Center Svcs
Aging Waiver Services
Alcohol & Drug Treatment Svcs
Case Management/Lock In Fee
Clinic Services, Mental
Contract Physician
Dental Services
DSS Prepaid Health Plan
Group Pre/Postnatal Education +
Health Maintenance Org. Services
Home and Community Based Svcs
Home Health Service
ICF1
ICF2
ICF/MR1
ICF/MR2
ICF/MR3
Day Treatment Services
Kidney Dialysis
Hospital, Inpatient General
Hospital, Outpatient General
Lab and Radiology
Medical Supplies
Medical Transportation
Nursing Anesthetist - Midwife
Nutritional Assessment/Counseling +
Occupational Therapy
Optical Supplies
Osteopathic Services
Pediatric/Family Nurse Practitioner
Perinatal Care Coordination +
Personal Care Services
Pharmacy
Physical Therapy
Physician Services
Podiatrist Services
Pre/Postnatal Home Visits +
Pre/Postnatal Psychosocial Counseling +
Private Duty Nursing
Psychologist Services
QMB Only (Crossover Services)
Rural Health Services
Speech and Hearing
SNF1
SNF2
Targeted Case Management
Vision Care
Well Child Care (CHEC/EPSDT)

\+ *Baby-Your-Baby Services*

Boxes 32-33.
American Board of Medical Specialty Certificate. (Applicable to Physicians only) – If you are a physician, enter your American Board of Medical Specialties (see page 6 for specialty list).

Box 34. Type of Practice . – Check the box that applies to your type of practice.

Remittance Statement Control Information. These fields control the format of your Remittance Statements.

Box 35. Remit Type (Suspended Claims Information). Check one box.

Once* = Print Suspended Claims Only Once (When claims suspend in the Medicaid system, a Remittance Statement will be sent to you one time notifying you of the suspended claim).
All = Print All Suspended Claims (When claims suspend in the Medicaid system, a Remittance Statement will be sent to you weekly, until the claims are properly adjudicated).
None = Do not print Suspended Claims (You will not receive a Remittance Statement for Suspended Claims).

Box 36. Remit Print Sequence. Check one box.
This indicator controls the order in which your Remittance Statements will print (e.g., If you select Recipient ID, all of your claims will begin with the Recipient ID, then the claim information).

Recipient Name*
Recipient ID
Provider Number
Medical Record Number
Invoice (Pharmacies Only).

Box 37. Remittance Type. Check one box.

Paper*
CD and Paper
Electronic (EDI), (you must enter your EDI Trading Partner number in box 20).
Both Paper and Electronic (EDI), (you must enter your EDI Trading Partner number in box 20).
Paper, Electronic (EDI) and CD, (you must enter your EDI Trading Partner number in box 20).

* indicates the default

Box 38. Reserved for future use.

Box 39. Name, Date, Title, and Phone number of the person completing the application. This field is for reference and contact purposes.

Completing the Utah Medicaid Provider Agreement.

Enter the name and address of the provider on Page 1, sign and date Page 7 of the Agreement.

Who must sign the Provider Agreement?

Professional providers. (i.e., physicians, osteopaths, physical therapists, etc.) – The agreement must be signed by the Licensed Professional.

Corporations / Institutions. (i.e., home health agencies, pharmacies, ambulances, etc.) – The agreement must be signed by a corporate manager, officer, administrator, business owner, etc.

Group Practices and FQHCs. – A separate agreement must be signed by the person in charge of the group or FQHC (i.e., corporate officer, sponsoring physician, an affiliate, etc.). Each affiliate **will** need to sign their own agreement as part of their individual application which affiliates them to the group or FQHC.

Establishing a Group Practice.

Enrollment of a group practice requires the following:

1. Application and agreement for the group practice.
2. Application(s), agreement(s) and professional license(s) for each individual with the group (Note: A minimum of one (1) affiliate is required for the establishment of a group practice).

Out-of-State Provider Numbers.

Out of state provider numbers are only eligible for reimbursement until the expiration date of the most current license we have on file. In order to stay current, you MUST send us a copy of your license each time it is renewed.

	GENERAL SPECIALTY CERTIFICATES		SUB-SPECIALTY CERTIFICATES
	ALLERGY & IMMUNOLOGY		DIAGNOSTIC LABORATORY IMMUNOLOGY
	ANESTHESIOLOGY		CRITICAL CARE MEDICINE
			PAIN MANAGEMENT
	COLON & RECTAL SURGERY		
	DERMATOLOGY		DERMATOPATHOLOGY
			DERM IMMUN/DIAG LAB IMMUN
	EMERGENCY MEDICINE		PEDIATRIC EMERGENCY MEDICINE
	FAMILY PRACTICE		GERIATRIC MEDICINE
			SPORTS MEDICINE
	INTERNAL MEDICINE		CARDIAC ELECTROPHYSIOLOGY
			CARDIOVASCULAR DISEASE
			CRITICAL CARE MEDICINE
			DIAGNOSTIC LABORATORY IMMUNOLOGY
			ENDOCRINOLOGY & METABOLISM
			GASTROENTEROLOGY
			GERIATRIC MEDICINE
			HEMATOLOGY
			INFECTIOUS DISEASE
			MEDICAL ONCOLOGY
			NEPHROLOGY
			PULMONARY DISEASE
			RHEUMATOLOGY
	NEUROLOGICAL SURGERY		CRITICAL CARE MEDICINE
	NUCLEAR MEDICINE		NUCLEAR RADIOLOGY (W\ABR)
			RADIOISOTOPIC PATHOLOGY (W\ABPA)
	OBSTETRICS & GYNECOLOGY		CRITICAL CARE MEDICINE
			GYNECOLOGIC ONCOLOGY
			MATERNAL & FETAL MEDICINE
			REPRODUCTIVE ENDOCRINOLOGY
	OPHTHALMOLOGY		
	ORTHOPAEDIC SURGERY		HAND SURGERY
	OTOLARYNGOLOGY		
	ANATOMIC & CLINICAL PATHOLOGY		BLOOD BANKING
	ANATOMIC PATHOLOGY		CHEMICAL PATHOLOGY
	CLINICAL PATHOLOGY		CYTOPATHOLOGY
			DERMATOPATHOLOGY
			FORENSIC PATHOLOGY
			HEMATOLOGY
			IMMUNOPATHOLOGY
			MEDICAL MICROBIOLOGY
			NEUROPATHOLOGY
			PEDIATRIC PATHOLOGY
			RADIOISOTOPIC PATHOLOGY
	PEDIATRICS		ADOLESCENT MEDICINE
			PEDIATRIC CARDIOLOGY
			PEDIATRIC CRITICAL CARE MEDICINE
			DIAGNOSTIC LABORATORY IMMUNOLOGY
			PEDIATRIC GASTROENTEROLOGY
			PEDIATRIC INFECTIOUS DISEASE
			PEDIATRIC ENDOCRINOLOGY
			PEDIATRIC HEMATOLOGY-ONCOLOGY
			PEDIATRIC NEPHROLOGY
			PEDIATRIC EMERGENCY MEDICINE
			PEDIATRIC PULMONOLOGY
			NEONATAL-PERINATAL MEDICINE
			RHEUMATOLOGY
	PHYSICAL MEDICINE & REHABILITATION		
	PLASTIC SURGERY		HAND SURGERY
	AEROSPACE MEDICINE		UNDERSEAS MEDICINE
	OCCUPATIONAL MEDICINE		
	PUBLIC HEALTH & GENERAL PREVENTATIVE MEDICINE		
	PSYCHIATRY		CHILD AND ADOLESCENT PSYCHIATRY
	NEUROLOGY		GERIATRIC PSYCHIATRY
	NEUROLOGY W/SPECIAL QUALIFICATIONS IN CHILD NEUROLOGY		NEUROPHYSIOLOGY
	RADIOLOGY		NUCLEAR RADIOLOGY
	DIAGNOSTIC RADIOLOGY		
	RADIOLOGY ONCOLOGY		
	THERAPEUTIC RADIOLOGY		
	RADIOLOGICAL PHYSICS		
	SURGERY		GENERAL VASCULAR SURGERY
			HAND SURGERY
			PEDIATRIC SURGERY
			SURGICAL CRITICAL CARE
	THORACIC SURGERY		
	UROLOGY		